

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005273

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 318

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED MAR 13 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph.		c. CITY OR TOWN St. Joseph.	
Length of stay in 1b Life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Meth. Hosp. & Med. Center		d. STREET ADDRESS (If outside, give location) 424 North 21st Street	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE MOSS BARROW		4. DATE OF DEATH Month Day Year March 6, 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1893
9. AGE (last birthday) 69		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (City and state or country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Josiah B. Moss		13b. MOTHER'S MAIDEN NAME Mary Leach	
14. NAME OF HUSBAND OR WIFE J. Doyle Barrow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [Redacted]	
17. INFORMANT Mr. J. Doyle Barrow		Address St. Joseph, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Carcinomatosis, generalized DUE TO (c) Carcinoma of Right Breast		INTERVAL BETWEEN ONSET AND DEATH 3 days 18 mo 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Sept 1, 1960 to March 6, 63 and last saw her alive on March 6, 63 Death occurred at 7:30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F.G. Thompson M.D.		22b. ADDRESS 902 Edmond St St Joseph, Mo	
22c. DATE SIGNED 3/8/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE March 9, 1963	23c. NAME OF CEMETERY OR CREMATORY D.W. Newcomer & Sons Crematory	
23d. LOCATION (City, town, or county) Kansas City, Missouri			
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Mar. 12, 1963	
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

BY AFFIDAVIT OF F.G. Thompson, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

VS 300  
Rev. 4/59

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USE BLACK INK  
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TYPEWRITER RIBBON

Permit issued 3-7-63

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond H. Hoov

Licensed Embalmer No. 5147

P. O. Address St Joseph Ho

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.